STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING 01 B. WING	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/12/13 Facility Number: 000223 Provider Number: 155330 AIM Number: 100267680 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Salem Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping	K0000	Please find the enclosed plan of correction for survey ending 2-12-13. Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance, feel free to contact me with any questions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	rooms. The facility has a capacity of 92 and had a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/19/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of over 100 doors to the corridor were equipped with positive latches and latched into the door frame. This deficient practice could affect up to 10 residents at a time, as well as staff and visitors while in the Physical Therapy room or Activity room. Findings include: Based on observations on 02/12/13 between 12:00 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor and Administrator, the doors from the corridor into the Physical Therapy room and into the Activity room were not provided with positive latches. Both doors were equipped with deadbolts	K0018	1. The doors in the therapy gym and activity room had positive latches installed. 2. Facility inspected to ensure no further areas of concern. 3. Maintenance Director in-serviced on K018, K021, K029, K046, K069 regulation (See Attachment A) by Executive Director on 2-26-13. Weekly Preventative Maintenance updated to include inspection of doors (See Attachment B). 4. The Executive Director or designee will complete a Maintenance Audit (See Attachment C) weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	03/01/2013

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	only. This was acknowledged by the Maintenance Supervisor and the Administrator at the time of each observation. 3.1-19(b)			

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 1 sets of double doors to the corridor, hazardous area doors, were arranged to automatically close or close upon activation of the fire alarm system. This deficient practice could affect up to 61 residents from the 100, 200, and 300 halls, as well as staff and visitors while in the main dining room. Findings include: Based on observation on 02/12/13 at 12:20 p.m. during a tour of the facility with the Maintenance Supervisor and the Administrator, the set of double doors between the kitchen and dining room closed in the same direction and were equipped with an astragal on one of the	K0021	1. All affected areas had coordinators installed to allow the astragal side of the door to close first. 2. Facility inspected to ensure no further areas of concern. 3. Maintenance Director was in-serviced on K018, K021, K029, K046, K069 regulation (See Attachment A) by Executive Director on 2-26-13. Preventative Maintenance updated to include inspection of doors (See Attachment B). 4. The Executive Director or designee will complete a Maintenance Audit (See Attachment C) weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	03/01/2013

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	doors. When first observed, these double doors were held open by the door with an astragal creating a one inch gap between the doors. This was acknowledged by the Maintenance Supervisor and the Administrator at the time of observation. 3.1-19(b)			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 3 of 5 doors to the kitchen, hazardous area doors, were equipped with positive latches and latched into their door frames. This deficient practice could affect up to 61 residents from the 100, 200, and 300 halls, as well as staff, and visitors while in the main dining room. Findings include: Based on observations on 02/12/13 between 12:15 p.m. and 12:30 p.m. during a tour of the facility with the Maintenance Supervisor and the Administrator, the set of double doors between the kitchen and dining room, and the single door on the right between the kitchen and the dining room were not provided with positive latches. Both were equipped with deadbolt latches only.	K0029	1. All affected doors have had positive latches installed and latched into their door frames. 2. Facility inspected to ensure no further areas of concern. 3. Maintenance Director was in-serviced on K018, K021, K029, K046, K069 regulation (See Attachment A) by Executive Director on 2-26-13. Preventative Maintenance updated to include inspection of doors (See Attachment B). 4. The Executive Director or designee will complete a Maintenance Audit (See Attachment C) weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	03/01/2013

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	Furthermore, the dining room was open to the egress corridor. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)			

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K0046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review and interview, the facility failed to provide documentation to ensure 1 of 1 battery powered light sets was tested annually for 90 minutes. LSC 101, Section 7.9.3 requires a functional test shall be conducted annually on every required emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on review of the battery light testing log in the Life Safety Code book on 02/12/13 at 11:35 a.m. with the Maintenance Supervisor and Administrator present, there was no written documentation to show the battery powered emergency light set at the generator was tested annually for a duration of ninety minutes. The Maintenance Supervisor confirmed the facility lacked a ninety minute annual test for the battery back up light set at the time	K0046	1. Battery-operated lights were tested for 90 minutes. 2. Facility inspected to ensure no further areas of concern. 3. Maintenance Director was in-serviced on K018, K021, K029, K046, K069 regulation (See Attachment A) by Executive Director on 2-26-13. Preventative Maintenance policy states that annual testing will be completed. Maintenance has written “90 minutes” on the Test Log so further inspection can verify how long the test was conducted (See Attachment D). 4. The Executive Director or designee will complete a Maintenance Audit (See Attachment C) weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility’s CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	03/01/2013

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	of record review. 3-1.19(b)			

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K0069 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect mostly kitchen staff. Findings include: Based on review of the Rangehood Inspection reports on 02/12/13 at 11:05 a.m. with the Maintenance Supervisor and the Administrator present, documentation for the kitchen range hood showed it was	K0069	1. New contract signed with company to complete cleaning at least semi-annually. 2. Facility inspected to ensure no further areas of concern. 3. Maintenance Director was in-serviced on K018, K021, K029, K046, K069 regulation (See Attachment A) by Executive Director on 2-26-13. Preventative Maintenance updated to include semi-annual cleaning of kitchen exhaust systems by contracted provider (See Attachment E). 4. The Executive Director or designee will complete a Maintenance Audit (See Attachment C) weekly times 4 weeks, then monthly times 3 months, then quarterly for at least 6 months. The audits will be reviewed during the facility's CQI meetings and issues will be addressed and the above plan will be altered accordingly if the threshold is not 95% or above.	03/01/2013

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	only being cleaned once a year. The most recent date the range hood was cleaned was 11/28/12. This was confirmed by the Maintenance Supervisor at the time of record review. 3.1-19(b)			